PRINTED: 08/24/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDI	CAID SERVICES			(OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/03/2011		
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			STREET 7 700 E 2 GARY,	DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F0000	Complaints INO Complaint INO Federal/State de allegations are	0093908 substantiated, eficiencies related to the cited at F 282 and F 367. August 2 and 3, 2011 r: 000368 er: 15E187 100275220 RN e:	F0000			
		cies also reflect State n accordance with 410 IAC				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review completed 8/4/11

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

16.2.

Event ID:

BTVG11 Facility ID:

000368

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/03/2	ETED
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY					DDRESS, CITY, STATE, ZIP CODE 1ST AVE N46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	· · · · · · · · · · · · · · · · · · ·	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0282 SS=D	Cathy Emswiller RN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview the facility failed to ensure physicians' orders were followed for residents to receive super cereal (cereal that provides more nutrients and calories) for 2 of 4 residents reviewed for weight loss in a sample of 6. (Resident #F and #G) Findings include: 1. On 8/3/11 at 8:46 a.m. Resident #F was observed sitting in his wheelchair in the dining room. He had oatmeal on his plate on the table in front of him. The record for Resident #F was reviewed on 8/2/11 at 9:10 a.m. His diagnoses included, but was not limited to, hypothyroidism, behaviors, osteoporosis, cerebral palsy, and constipation. A physician's order dated 7/20/11, indicated the resident was to received super cereal in the morning and a nutritional supplement one can daily.		F02	282	Corrective Action:Interview wheld with Cook 1 to understa why he did not serve the sup cereal when whole milk and butter was available in the refrigerator and brown sugar available in the store room. In review of the procedure of dot the inventory and submitting out of stock forms was done. Cook 1 was taken downstains shown where the brown sugar was located. It was also discussed that it was no except for not serving the super cere even if he thought we did not have the needed food items of a grocery store which we have taken less than 5 minut get the items he thought he needed. The food inventory done for a 2 week menu cycl and is submitted 1 week prious each menu cycle. Super Cere was given to Resident # F and Resident # G on 8/4/2011. Residents At Risk: No other residents were affected. Measures Put Into Place:In-Service held with die staff on Saturday 8/6/2011 ard review of foo usage, inventor recipe for super cereal and the staff on super cereal and the staff on super cereal and the staff on super cereal and the super	nd er ne was A bing the s and ar use eal treet ould es to is e r to real ad lo etary and a ry,	09/02/2011

000368

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15E187	B. WIN			08/03/2	011
NAME OF	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				700 E 2	1ST AVE		
	SIMMONS LOVING CARE HEALTH FACILITY			L	IN46407		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	+	TAG	importance of following the o	lint.	DATE
	1	early weights and vital			orders.Cool 1 will be require		
	1	icated the resident			repeat his orientation and wi		
	1 -	unds on 6/5/11 and 114			monitored closely. Tray Acc		
	pounds on 7/5/1	1, 7/18/11, and 7/25/11.			Q.A. will be completed for m	eals	
					served by CooK 1 for 2 week		
	On 8/2/11 at 9:0	0 a.m. the Director of			errors are detected with Coo	k 1	
	Nursing provide	d a list of resident who			he will be terminated.TRAY ACCURACY QA Procedure		
	l • • •	and resident #F's name			Circle Y = Yes N = No Surve		
	was list for the n				meal 3 times a week. Chec	-	
	was list for the li	nonth of sury.			tray accuracy of 5-10 resider		
	Interview with the Cook #1 on 8/3/11 at				trays Note any errors and the		
					corrective action taken DATE	Ξ:	
	1	ited none of the resident's				-	
	1 ^	ereal today due to the			MEAL SURVEYOR		
	1 -	ave the ingredients to			SURVETUR		
	make the super of	cereal. He further			RESIDENT NAMEDISHES		
	indicated all resi	dent's received plain			DRYMEAL PLATE		
	oatmeal today fo	or breakfast.			CORRECTFOODCONSISTE	ENC	
					Y CORRECTBEVERAGE		
	Interview with the	ne Cook #1 on 8/3/11 at			CORRECTSILVERWARE		
	11:00 a m indic	cated he had not been at			PRESENT Y NY NY NY N		
	1	eks so he did not know			Y NY NY NY NY N		
	when the facility				RESIDET NAMEDISHES		
	1				DRYMEAL PLATE		
	~	worked two weeks ago			CORRECTFOODCONSISTE	ENC	
	1	nad the ingredients to			Y CORRECTBEVERAGE		
	make the super of	cereal.			CORRECTSILVERWARE		
	2. On 8/3/11 at 8:45 a.m. Resident #G was observed sitting in his wheelchair in the dining room. He had no cereal sitting in front of him and his meal was half gone				PRESENT Y NY NY NY N		
					Y NY NY NY NY N		
					RESIDENT NAMEDISHES		
					DRYMEAL PLATE		
					CORRECTFOODCONSISTE	ENC	
	from his plate.	-			Y CORRECTBEVERAGE		
					CORRECTSILVERWARE PRESENT		
	The record for R	lesident #G was reviewed			Y NY NY NY NY N		
					Y NY NY NY NY N		
	1 011 0/3/11 at 8:10	a.m. His diagnoses					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
		15E187	B. WIN			08/03/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIER				1ST AVE		
SIMMONS LOVING CARE HEALTH FACILITY				1	IN46407		
						-	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	DATE
IAG			+	IAG	Monitoring & Q.A.The tray		DATE
	· ·	s not limited to, edema of			accuracy log will be complete	ed by	
		ities, hypertension, and			the Administrative Designee	, ,	
	Alzheimer's Dise	ease.			reviewed by the Administrato		
					weekly. Q.A. Committee will		
	A physician's ord	ler dated 7/17/11,			meet in one month to determ		
	indicated the resi	dent was to receive super			on-going compliance evaluat	tion	
	cereal for breakfa	ast.			and need for in-service education.AddendumQ.A.		
					Committee will review tray		
	A dietary note da	ated 7/17/11, indicated			accuracy quarterly thereafter	and	
	1 *	stered Dieticians follow			the Dietician will discuss defi		
		ll on 7/15/11 following			practices. Completion		
		ing difficulty swallowing			Date9/2/2011		
		isode. The resident was					
		al today and ate 100% of					
	1 ^	cluding beverage and					
	jello without cou	ghing or choking. His					
	July weight was	129 pounds, June weight					
	was 129 pounds,	and January was 138					
	pounds. This wa	s a decrease of 7% in six					
	months. The pla	n was to have speech					
	therapy screen fo	or coughing episodes,					
		for July, and offer super					
	cereal at mooning	-					
		D					
	On 8/2/11 at 0.00	a.m. the Director of					
	Nursing provided a list of resident who had lost weight and Resident #G's name						
	was list for the months of June and July.						
	Interview with the Cook #1 on 8/3/11 at						
	1	ted none of the resident's					
	received super ce	ereal today due to the					
	facility did not ha	ave the ingredients to					
	make the super c	ereal. He further					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		A. BUILDIN		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/03/2011			
	PROVIDER OR SUPPLIER		B. WING 00/03/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN46407					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	III PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
		dent's received plain					5.112	
	Interview with the Cook #1 on 8/3/11 at 11:00 a.m., indicated he had not been at work for two weeks so he did not know when the facility ran out of the ingredients. He worked two weeks ago and the facility had the ingredients to make the super cereal. This Federal tag relates to complaint IN00093908. 3.1-35(g)(2)							
F0367 SS=D	attending physicia Based on observation interview the factor therapeutic diets physician for 2 of weight loss in a stresidents not receive (cereal with addicalories). (Residents includents includents includents)	ation, record review and ility failed to provide as prescribed by the f 4 residents reviewed for sample of 6 related to the eiving super cereal tional nutrients and ent #F and #G)	F0367	7	Corrective Action:Interview we held with Cook 1 to understate why he did not serve the supportereal when whole milk and butter was available in the refrigerator and brown sugar available in the store room. The review of the procedure of dot the inventory and submitting out of stock forms was done. Cook 1 was taken downstains shown where the brown sugar was located. It was also discussed that it was no excutor not serving the super cere	nd her was A bing the s and ar	09/02/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: A.		LDING	00	COMPLETED	
		15E187	B. WIN			08/03/2	011
NAME OF	DDOVIDED OD SLIDDI IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				700 E 2	1ST AVE		
	SIMMONS LOVING CARE HEALTH FACILITY			<u> </u>	N46407		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		4	DATE
		ting in his wheelchair in			even if he thought we did no have the needed food items		
		He had oatmeal on his			are located right across the		
	plate on the table	e in front of him.			from a grocery store which w		
					have taken less than 5 minut	tes to	
	The record for R	esident #F was reviewed			get the items he thought he		
	on 8/2/11 at 9:10	a.m. His diagnoses			needed. The food inventory		
	included, but wa				done for a 2 week menu cycle and is submitted 1 week prior		
	· ·	behaviors, osteoporosis,			each menu cycle. Super Ce		
	cerebral palsy, and constipation. A physician's order dated 7/20/11, indicated the resident was to received super cereal in the morning and a				was given to Resident # F ar		
					Resident #G on		
					8/4/2011.Residents At Risk:N	1 0	
					other residents were		
					affected.Measures Put Into Place:In-Service held with di	otony	
	_				staff on Saturday 8/6/2011 a		
	nutritional suppl	ement one can daily.			review of foo usage, inventor		
					recipe for super cereal and the		
	I -	early weights and vital			importance of following the d		
	signs record, ind	icated the resident			orders.Cool 1 will be required		
	weighed 120 por	unds on 6/5/11 and 114			repeat his orientation and wi		
	pounds on 7/5/1	1, 7/18/11, and 7/25/11.			monitored closely. Tray Acc Q.A. will be completed for m		
					served by CooK 1 for 2 week		
	On 8/2/11 at 9:0	0 a.m. the Director of			errors are detected with Coo		
	Nursing provide	d a list of resident who			he will be terminated.TRAY		
	1	and resident #F's name			ACCURACY QA Procedure		
	was list for the n				Circle Y = Yes N = No Surve meal 3 times a week. Chec		
	was not for the n	nomin of vary.			tray accuracy of 5-10 resider		
	Interview with the	ne Cook #1 on 8/3/11 at			trays Note any errors and the		
					corrective action taken DATE		
	9:15 a.m., indicated none of the resident's received super cereal today due to the facility did not have the ingredients to make the super cereal. He further					-	
					MEAL		
					SURVEYOR		
					RESIDENT NAMEDISHES		
		dent's received plain			DRYMEAL PLATE		
	oatmeal today fo	or breakfast.			CORRECTFOODCONSISTE	ENC	
					Y CORRECTBEVERAGE		
	Interview with the	ne Cook #1 on 8/3/11 at			CORRECTSILVERWARE		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		15E187	B. WIN			08/03/2	011
		<u></u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		700 E 2	1ST AVE		
	IS LOVING CARE H				IN46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL					COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
	1	ated he had not been at			PRESENT Y NY NY NY N		
		eks so he did not know			Y NY NY NY NY N		
	when the facility				RESIDET NAMEDISHES		
	ingredients. He	worked two weeks ago			DRYMEAL PLATE		
	and the facility h	and the ingredients to			CORRECTFOODCONSISTE	ENC	
	make the super of	ereal.			Y CORRECTBEVERAGE		
					CORRECTSILVERWARE PRESENT		
	2. On 8/3/11 at 8	8:45 a.m. Resident #G			Y NY NY NY N		
	was observed sit	ting in his wheelchair in			Y NY NY NY N		
		He had no cereal sitting			RESIDENT NAMEDISHES		
	in front of him and his meal was half gone from his plate.				DRYMEAL PLATE	-NO	
					CORRECTFOODCONSISTE Y CORRECTBEVERAGE	INC	
					CORRECTSILVERWARE		
	The record for R	esident #G was reviewed			PRESENT		
		a.m. His diagnoses			Y NY NY NY N		
		s not limited to, edema of			Y NY NY NY NY N		
	· ·	nities, hypertension, and			Monitoring & Q.A.The tray accuracy log will be complete	ad by	
	Alzheimer's Dise				the Administrative Designee	•	
	Aizheimei s Dise	sase.			reviewed by the Administrato		
		1 1 1 1 7 1 7 1 1 1			weekly. Q.A. Committee will		
		der dated 7/17/11,			meet in one month to determ		
		ident was to receive super			on-going compliance evaluat and need for in-service	ion	
	cereal for breakf	ast.			education.AddendumQ.A.		
	l				Committee will review tray		
	1 -	ated 7/17/11, indicated			accuracy quarterly thereafter		
	_	istered Dieticians follow			the Dietician will discuss defi	cient	
	1	ll on 7/15/11 following			practices.Completion		
	the resident having difficulty swallowing and a choking episode. The resident was observed at a meal today and ate 100% of his pureed diet including beverage and jello without coughing or choking. His				Date9/2/2011		
	l *	129 pounds, June weight					
	1 -	and January was 138					
	_	as a decrease of 7% in six					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO.	NSTRUCTION 00	COMPI			
111,212,11	or conditions	15E187		LDING	08/03/2011			
			B. WIN		DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER		700 E 21ST AVE					
SIMMON	IS LOVING CARE H	IEALTH FACILITY		GARY, I				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	l '	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
IAG		n was to have speech		IAG			DAIL	
	1	or coughing episodes,						
		For July, and offer super						
	cereal at mooning	-						
		a.m. the Director of						
		d a list of resident who						
		nd Resident #G's name						
	was list for the m	nonths of June and July.						
	Interview with the Cook #1 on 8/3/11 at							
	9:15 a.m., indicated none of the resident's							
	l '	ereal today due to the						
	_	ave the ingredients to						
	make the super c	ereal. He further						
	indicated all resid	dent's received plain						
	oatmeal today fo	r breakfast.						
	Interview with th	ne Cook #1 on 8/3/11 at						
		ated he had not been at						
	· ·	eks so he did not know						
	when the facility							
		worked two weeks ago						
	-	ad the ingredients to						
	make the super c	•						
	•							
		relates to complaint						
	IN00093908.							
	3.1-21(b)							
	3.1 21(0)							